[Reported to the Louisville Clinical Society.]

CONGENITAL IMPERFORATE ANUS WITH FECAL IMPACTION EXTENDING ABOVE THE UMBILICUS.

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TWO months ago I was consulted by a young lady, 22 years of age, from Southern Indiana, who had a tumor in the lower abdomen extending above the umbilicus. By the sense of touch the tumor might easily have been confounded with calcareous degeneration of a myomatous uterus. The girl was otherwise apparently healthy, and while she was not large, her color was good, and she was supposed to be in fairly good general health.

Inquiry elicited the following history from her mother: "She was born with an imperforate anus, but with an opening about a quarter of an inch in diameter connecting the bowel with the vagina just above the osteum vaginæ. She had trouble in passing her feces since birth, but when 2 years old a perceptible enlargement was observed in the left side of the abdomen low down. This enlargement gradually increased until it was much larger than a child's head. She finally had but one fecal evacuation a month, that being the result of persistent and continued large doses of salts, and this confined her to bed for about two weeks because of the intense pain resulting from the action, it being then almost liquid and passed into the vagina through the recto-vaginal opening."

The fecal concretion passed down within one inch of the perineal surface, and when my finger was pushed through the opening between the vagina and rectum it was found that the entire pelvis was filled with fecal matter, pressing the uterus firmly in front against the pubes. Pressing from above the umbilicus the fecal impaction could be forced firmly against the perineum.

An artificial anus was made about an inch posterior to the vagina, at a depression which appeared to be surrounded by the sphincter ani. After making the anal opening, the mucous membrane from the rectum was pulled down and stitched to the external parts so as to make a mucous lining to the entire tract. The fecal accumulation was cleansed out from the pelvis and the entire cavity. The bowel at some points was three or four inches in diameter. The fecal matter removed was free from odor and was almost dry. She was given purgatives regularly, changing the remedy as indicated, and the bowels were washed out daily with a Wales bougie so as to put the water directly into the colon. Her bowels moved every day, she could then feel the sphincter muscles contract. By introducing the finger into the anus the muscular contraction could also be felt.

The colon having contracted down to one-thirds over its former caliber, we operated to close the opening between the rectum and vagina. The opening could not be brought together laterally, but the recto-vaginal wall was relaxed and could be pulled down with ease against the perineal band between the anus and the vagina which was about the size of a finger and rather dense and unyielding. The upper part of the perineal body was denuded where it joined the recto-vaginal opening, and then an incision was made laterally and above, dividing the rectum from the vagina for about one-fourth of an inch in depth, then the rectal layer was turned into the rectum and the vaginal layer into the vagina. With a curved needle a heavy silkworm-gut suture was introduced through the perineal body and carried around the recto-vaginal opening between the rectum and vagina and outside the incision dividing these layers, and finally brought out at a corresponding point on the opposite side of the perineum, the suture being entirely buried, except where the ends protruded through the perineum. With the vaginal flap pressed forward and the rectal flap backward the suture was drawn tightly and shotted so as to entirely close the opening; two other sutures were passed in the same manner and shotted, so that the closed opening had a raw surface of a half-inch in thickness brought together, giving a good support without destruction of tissue. The rectum was washed out daily and she was given purgatives to keep the bowels moving. The sutures were not removed for twelve days, when union was perfect, and the recto-vaginal wall at the point of the fistula was thick and strong. The girl is entirely relieved, and will probably have good control of her fecal evacuations.

The most marked feature about this case is, that there should have been so slight general symptoms from the enormous amount of retained fecal matter, and the length of time the trouble had existed

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